



JohnWHITE_{DDS}

Master of Academy of General Dentistry • Fellow of Academy of Dentistry International

Patient Information

► Welcome to our practice! Please take a moment to enter or update your information to help us provide you with the best dental care possible.

Your Information

Title: (Mr./Mrs./Ms./Dr./etc.) _____

Today's Date: ____/____/____

Last Name: _____

First Name: _____ M.I.: _____

Preferred Name: _____

Email: _____

Date of Birth: ____/____/____

Current Occupation: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Family Status: Single Married Child Other _____ Gender: Female Male Other _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____ - _____

Work Phone: (____) ____ - _____ Ext. _____

Mobile Phone: (____) ____ - _____

Best time to call: _____

Party Responsible for Payment

Who will be responsible for payment? Patient (*leave this section blank*) Other Party

Title: (Mr./Mrs./Ms./Dr./etc.) _____ Relationship to Patient: Spouse Parent Other _____

Last Name: _____

First Name: _____ M.I.: _____

Email: _____

Date of Birth: ____/____/____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Family Status: Single Married Child Other _____ Gender: Female Male Other _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____ - _____

Work Phone: (____) ____ - _____ Ext. _____

Mobile Phone: (____) ____ - _____

Best time to call: _____

Referring Information

How did you hear about our practice and whom may we thank for referring you to us?

Internet Search

Yellow Pages

Newspaper

Another dental office

School

Work

Person/Other: _____

Primary Dental Insurance Information

Insured's Relationship to Patient: Self Spouse Parent Other

Insured's Title: (Mr./Mrs./Ms./Dr./etc.) _____

Insured's Last Name: _____ First Name: _____ M.I.: _____

Insured's Date of Birth: ____/____/____

Insured's Home Address: _____
City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____

Insured's Employer Address: _____
City: _____ State: _____ Zip Code: _____

Insurance Plan Name: _____ Policy Group Number: _____

Insured's I.D. Number: _____

Claim Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Plan Phone Number for Providers: (____) ____ - _____ Ext. _____

Secondary Dental Insurance Information

Insured's Relationship to Patient: Self Spouse Parent Other

Insured's Title: (Mr./Mrs./Ms./Dr./etc.) _____

Insured's Last Name: _____ First Name: _____ M.I.: _____

Insured's Date of Birth: ____/____/____

Insured's Home Address: _____
City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____

Insured's Employer Address: _____
City: _____ State: _____ Zip Code: _____

Insurance Plan Name: _____ Policy Group Number: _____

Insured's I.D. Number: _____

Claim Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Plan Phone Number for Providers: (____) ____ - _____ Ext. _____

I hereby acknowledge that I have answered these questions accurately and truthfully to the best of my knowledge. I agree to report any change of this information to this practice at the earliest possible time.

Signature of patient, or parent, or guardian (responsible party): _____

Print Name: _____ Relationship to the patient: _____ Date: ____/____/____